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June 24, 2004

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# Acquisition

Direct Care Medical Services Contracts  
(D-2004-094)

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Department of Defense  
Office of the Inspector General

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### **Acronyms**

DCADS	Defense Contract Action Data System
FAR	Federal Acquisition Regulation
FBA	Franchise Business Activity
FICA	Federal Insurance Contributions Act
FISC	Fleet Industrial Supply Center
GAO	General Accounting Office
HCAA	Health Care Acquisition Activity
IG DoD	Inspector General of the Department of Defense
iMAP	Innovative Medical Acquisition Program
ISA	Individual Set-Aside
MATO	Multiple Award Task Order
MTF	Military Treatment Facility
NMLC	Naval Medical Logistics Command
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
USD(AT&L)	Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics



INSPECTOR GENERAL  
DEPARTMENT OF DEFENSE  
400 ARMY NAVY DRIVE  
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June 24, 2004

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE FOR ACQUISITION,  
TECHNOLOGY, AND LOGISTICS  
UNDER SECRETARY OF DEFENSE  
(COMPTROLLER)/CHIEF FINANCIAL OFFICER  
UNDER SECRETARY OF DEFENSE FOR PERSONNEL  
AND READINESS  
ASSISTANT SECRETARY OF DEFENSE (HEALTH  
AFFAIRS)  
ASSISTANT SECRETARY OF THE AIR FORCE  
(FINANCIAL MANAGEMENT AND COMPTROLLER)  
NAVAL INSPECTOR GENERAL  
AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: Report on Direct Care Medical Services Contracts (Report No. D-2004-094)

We are providing this report for review and comment. This is the second of two reports on medical services contracts. The Under Secretary of Defense for Personnel and Readiness and the Navy Surgeon General did not respond to the draft report. We considered comments from the Offices of the Under Secretary of Defense for Acquisition, Technology, and Logistics and the Under Secretary of Defense (Comptroller)/Chief Financial Officer; the Assistant Secretary of Defense (Health Affairs); the Army; and the Air Force when preparing the final report.

DoD Directive 7650.3 requires that all issues be resolved promptly. The comments received were responsive. We request that the Under Secretary of Defense for Personnel and Readiness provide comments on Recommendation 1. and the Navy Surgeon General provide comments on Recommendation 6. by August 24, 2004.

If possible, please send comments in electronic format (Adobe Acrobat file only) to [Audnorfolk@dodig.osd.mil](mailto:Audnorfolk@dodig.osd.mil). Copies of the management comments must contain the actual signature of the authorizing official. We cannot accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, they must be sent over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Questions should be directed to Mr. Scott J. Grady at (757) 872-4759 or to Mr. Michael A. Joseph at (757) 872-4815, ext. 223. See Appendix F for the report distribution. The team members are listed inside the back cover.

By direction of the Deputy Inspector General for Auditing:

Shelton R. Young  
Assistant Inspector General  
for Readiness and Logistics Support

# Office of the Inspector General of the Department of Defense

**Report No. D-2004-094**

(Project No. D2003LF-0127)

**June 24, 2004**

## Direct Care Medical Services Contracts

### Executive Summary

**Who Should Read This Report and Why?** Contract personnel responsible for procuring medical services and military and civilian health care professionals within the Military Health System and the Department of Veterans Affairs should read this report. Those responsible for acquiring and providing medical services should be interested in the need for an acquisition strategy that would allow the Military Departments to acquire direct care medical services in a more effective manner.

**Background.** The Under Secretary of Defense for Acquisition, Technology, and Logistics is the adviser to the Secretary and the Deputy Secretary of Defense for all matters relating to the DoD acquisition system and to procurement. The Office of the Assistant Secretary of Defense (Health Affairs) exercises authority, direction, and control over the facilities, funding, personnel, programs, and other medical resources within DoD. TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors.

TRICARE brings together the health care resources of the Army, the Navy, and the Air Force and supplements them with purchased care contracts that provide direct health care through health care institutions and individual providers in the civilian community. To help fill needs that cannot be satisfied through military treatment facilities or through purchased care contracts under TRICARE, the Military Departments issue direct care medical services contracts to augment the military and civilian staffs. In 2002, DoD spent about \$875 million to acquire medical services through direct care medical services contracts, excluding information technology contracts. We reviewed 125 of those contracts, valued at approximately \$73 million.

**Results.** We reviewed the contracts and the contracting processes to determine whether DoD was acquiring direct care medical services in the most effective manner. Although DoD and the Military Departments had ongoing initiatives regarding the acquisition of direct care medical services, an overall strategic approach is needed. Specifically, at the sites visited, there were examples of overlapping contracting efforts, inconsistent implementation of Federal procurement regulations, use of contracts that may impose an unnecessary administrative and financial burden on the Government, and inadequate oversight of competition achieved.

To improve the acquisition of direct care medical services, the Office of the Assistant Secretary of Defense (Health Affairs) and the Military Departments should develop a joint strategy for acquiring direct care medical services and strengthen guidance and oversight for those acquisitions. A more coordinated approach to acquiring direct care medical services in DoD should enable military treatment facilities to more effectively satisfy medical services requirements and address material management control weaknesses identified by this audit. Although we have cited examples where medical

services contracting could have been improved, nothing in this report should be interpreted as though the Military Health System has not provided quality health care to its beneficiaries. For detailed recommendations, see the Finding section. The issues identified in this report provide coordination opportunities for DoD and the Department of Veterans Affairs; therefore, the report will be forwarded to the DoD/Department of Veterans Affairs Joint Executive Council.

**Management Comments and Audit Response.** The Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics; the Acting Under Secretary of Defense (Comptroller)/Chief Financial Officer; the Assistant Secretary of Defense (Health Affairs); the Deputy Surgeon General of the Army; and the Office of the Air Force Surgeon General generally concurred with the findings and the intent of all the recommendations. Management comments were responsive. However, the Air Force disagreed with developing implementing policy on the appropriate use of forward funding, citing that the timing for the release of funding for medical services acquisitions needs to be addressed in order to permit procurement personnel to timely establish medical services contracts.

The Assistant Secretary of Defense (Health Affairs) commented that the examples cited in this report of forward funding are within the bounds of section 2410a, title 10, United States Code. We acknowledge that use of the statute is permissible and have revised our posture on the Navy's interpretation of the forward funding statute. However, due to the lack of uniformity regarding the use of Franchise Business Activity contracts to forward fund appropriations from one fiscal year for work performed in the next fiscal year, additional guidance would be appropriate. See the Finding section of the report for a discussion of management comments and the Management Comments section for the complete text of the comments.

The Under Secretary of Defense for Personnel and Readiness and the Navy Surgeon General did not respond to the draft report. We request that the Under Secretary of Defense for Personnel and Readiness and the Navy Surgeon General provide comments on the final report by August 24, 2004.

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## Background

**DoD Procurement.** The Under Secretary of Defense for Acquisition, Technology, and Logistics is the adviser to the Secretary and the Deputy Secretary of Defense for all matters relating to the DoD acquisition system and to procurement. The Under Secretary of Defense for Acquisition, Technology, and Logistics serves as the Defense Acquisition Executive, and in that capacity, establishes policy for acquisition plans and strategies and develops acquisition program guidance.

**Military Health System.** The Assistant Secretary of Defense (Health Affairs) is the principal staff assistant and adviser to the Under Secretary of Defense for Personnel and Readiness for all DoD health policies, programs, and activities. As such, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) exercises authority, direction, and control over the facilities, funding, personnel, programs, and other medical resources within DoD. Its responsibilities include establishing policies, procedures, and standards that govern DoD health care programs. The mission of the military health system is to enhance DoD and our Nation's security by providing health care support for the full range of military operations and sustaining the health of DoD beneficiaries.

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE brings together the health care resources of the Army, the Navy, and the Air Force and supplements them with purchased care contracts that provide direct health care through health care institutions and individual providers in the civilian community. Those purchased care contracts include networks of civilian health care professionals that supplement the direct health care resources of the Military Departments to improve access to high quality services while maintaining the capability to support military operations. To help fill needs that cannot be satisfied through DoD military treatment facility (MTF) personnel or through purchased care contracts under TRICARE, the Military Departments issue direct care medical services contracts to augment the direct health care military and civilian staffs of the Military Departments. For purposes of this report, we refer to those contracts as non-TRICARE medical services contracts.

**Military Departments.** Each Military Department has its own organizational structure in place for acquiring non-TRICARE medical services. The Military Department Surgeons General have delegated responsibility for medical services acquisitions to the Army Health Care Acquisition Activity (HCAA), the Naval Medical Logistics Command (NMLC), and the Air Force Medical Logistics Office. The organizational structure of those offices varies, as do the number and size of the contracting offices reporting to them.

The Army has the largest organizational structure dedicated to health care procurement. The Army acquires medical services through the HCAA and its contracting center, six regional contracting offices, and three contracting cells. Additionally, various Army MTFs sought contracting support from other agencies. HCAA Operating Instruction 04-02, "Procedures for Processing Contract Requirements," October 30, 2003, states that regional contracting offices may process requirements for commercial items up to \$5 million in value. HCAA



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Policy Letter 98-01, "HCAA Commercial Policy," April 21, 1998, designates health care services as commercial items. Thus, the contracting center procures non-TRICARE medical services valued at \$5 million or higher and regional contracting offices make purchases from \$500,000 to \$5 million. The contracting center also processes actions under \$5 million when the action covers more than one region, covers other agencies, or the regional contracting office requests. According to HCAA officials, contracting cells may make procurements up to \$500,000 for the Army.

The Navy also has a centralized approach. NMLC is the technical manager for the Bureau of Medicine and Surgery for all non-TRICARE health care services contracting and has approval authority for the technical specifications for all health care services contracts. According to NMLC officials, NMLC is the contracting office for personal services health care contracts, while Fleet Industrial Supply Center (FISC) Norfolk, Detachment Philadelphia, is the contracting office for non-personal services contracts over the simplified acquisition threshold of \$100,000. Procurements of \$100,000 or less may be made locally.

The Air Force structure is decentralized. The Air Force Medical Logistics Office has responsibility for medical services contract policy, but has no contracting warrants or authority. The Air Force directs MTFs to use base contracting resources, the Federal supply schedule through the Air Force partnership with the Department of Veterans Affairs, or other agencies' contracting authority for medical services acquisitions.

**Contractual Methods.** Contracting for health care professionals, such as physicians and nurses, is complex. It is often difficult to fill skilled health care vacancies, particularly in remote geographical locations. There are a variety of contractual methods available to help DoD medical facilities fill their supplemental needs, such as Federal supply schedule contracts, local contracts with individuals or commercial organizations, and nationwide or regional contracts that are delivery-order based. Appendix C provides information on the various contractual methods used by the Military Departments to acquire non-TRICARE medical services.

**Non-TRICARE Medical Services Contract Actions.** DoD accumulates data on contract actions over \$25,000 in the Defense Contract Action Data System (DCADS). According to DCADS data, DoD spent about \$1.2 billion in 2002 on non-TRICARE medical services contracts. Of that amount, approximately \$875 million was used to acquire services such as health care providers, laboratory testing services, and ancillary services; the rest was for health care information technology services.

## Objectives

Our overall audit objective was to evaluate the efficiency and effectiveness of DoD contracting practices and procedures for acquiring non-TRICARE medical services and to evaluate the management control program applicable to the audit objective.

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See Appendix A for a discussion of the scope and methodology and our review of the management control program and Appendix B for prior coverage related to the objective.

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## Acquisition of Direct Care Medical Services

Although DoD and the Military Departments had ongoing initiatives that may lead to improvements in the acquisition of direct care (non-TRICARE) medical services, the approach to acquiring those services remained fragmented. Specifically, the audit identified examples where the approach used by the Military Health System included:

- overlapping contracting efforts;
- inconsistent application and award of non-personal services contracts;
- liberal interpretation of forward funding guidance;
- different methods of awarding minimum guaranteed work under multiple award task order (MATO) contracts;
- inappropriate use of individual set-aside contracts; and
- inadequate oversight of competition achieved.

The OASD(HA) and the Military Departments need to develop a joint strategy and strengthen guidance and oversight to improve the acquisition of non-TRICARE medical services. A more coordinated approach to acquiring non-TRICARE medical services in DoD should enable the Military Health System to more effectively satisfy medical requirements.

## DoD and Military Department Initiatives

DoD and the Military Departments had ongoing initiatives that may lead to improvements in the acquisition of non-TRICARE medical services. Public Law 106-398, “National Defense Authorization Act for FY 2001,” October 30, 2000, requires the Secretary of each Military Department to establish at least one center of excellence in contracting for services. The Army designated HCAA as a center of excellence for health care services acquisitions and implemented the Innovative Medical Acquisition Program (iMAP) during FY 2002. The iMAP primarily consisted of Web-based contracting tools, including two large MATO contracts awarded as small business set-asides with nationwide coverage to promote inter-Service use.<sup>1</sup> However, as of December 2003, the Navy had not used the iMAP contracts, and the Air Force had used them only to a small extent, with the Army placing orders for Air Force MTFs. The Military Departments also formed a tri-Service working group to

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<sup>1</sup> A MATO contract is established when two or more awards are made from the same solicitation, resulting in a pool of pre-qualified vendors to perform the work of the contract. Appendix C includes an explanation of MATO contracts.

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improve medical services procurement. Although the group provides a forum to promote the inter-Service use of contracting resources, the group continues to struggle with contracting issues such as delegation of contracting authority among the Military Departments and the inability to delegate DoD personal services contracting authority to the Department of Veterans Affairs. Recent legislation intended to improve DoD acquisition of services is provided in Appendix D, and DoD and Military Department initiatives are discussed in more detail in Appendix E.

## Use of Contractual Resources

The DoD approach to acquiring non-TRICARE medical services was inconsistent and fragmented. Resources could have been more consistently and effectively used to acquire non-TRICARE medical services. Specifically, the audit identified examples where the acquisition approaches used by the Military Health System included:

- overlapping contracting efforts;
- implementing federal procurement regulations differently;
- extensively using contracts with individuals that may impose an unnecessary administrative and financial burden on the government; and
- inadequate oversight of competition achieved.

**Contracting Efforts.** MTFs did not always adhere to lines of contracting authority established within their respective Military Department. For instance, one Army MTF visited had locally issued 84 individual set-aside (ISA) contracts (contracts with individual health care providers), valued at \$3.6 million,<sup>2</sup> to satisfy nearly all of its FY 2002 non-TRICARE medical services requirements.<sup>2</sup> According to personnel from the MTF's cognizant Regional Contracting Office, at least 80 of the 84 ISAs could have been filled by existing Army contracts, reducing the burden of administering 84 separate contracts. Although Military Department regulations prescribe preferred sources to acquire non-TRICARE medical services, MTF personnel stated factors such as timeliness sometimes dictated the contracting office used by an MTF. For example, one Air Force and one Army MTF, in an effort to achieve a quicker turnaround, used a non-DoD agency<sup>3</sup> to fulfill its nursing requirements via a potentially illegal and unenforceable contract even though the Army had existing contracts for nursing services available for the same geographic area. Timeliness was also cited as the reason one Navy MTF used FISC San Diego to contract for \$1.5 million in

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<sup>2</sup> The Army reduced the number of ISA contracts from 84 in FY 2002 to 63 in FY 2003.

<sup>3</sup> As discussed in Inspector General of the Department of Defense Report No. D-2003-113, "Franchise Business Activity Contracts for Medical Services," June 30, 2003, MTFs sometimes went to the Department of the Treasury for medical services, including personal services.

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medical services during FY 2002 that should have been awarded through NMLC or FISC Norfolk, Detachment Philadelphia.

At times, the Military Departments procured through separate contracts the same types of medical services and, in some instances, in the same geographic area. According to Army and Navy contracting personnel, they generally do not consider use of each other's contracts to acquire non-TRICARE medical services. By reviewing DCADS data, we found eight potentially overlapping Army and Navy contracts for nursing and dental services. The DCADS data showed that both the Army and the Navy had contracts in the same geographic areas (Beaufort, South Carolina; Newport News, Virginia; Honolulu, Hawaii; and the District of Columbia) for the same services (nursing or dentistry).

Although we recognize that the Military Departments need their own contracting capabilities so that emergent requirements can be quickly satisfied, we believe more can be done to reduce duplication and improve efficiency in contracting organizations. OASD(HA) and the Military Departments need to reexamine the organizational structure of the medical contracting community to provide for greater sharing of resources and contracts among and within the Military Departments. Personnel interviewed stated that they were reluctant to use contracts originating from another Military Department in part because they believed their needs would not be filled in a timely manner. Contracting personnel also stated that they believed allowing another Military Department to use their department's contracts would result in increased administrative workload without a corresponding increase in resources.

**Personal and Non-Personal Services Contracts.** The Military Departments inconsistently applied and awarded non-personal services contracts for non-TRICARE medical services. Contracts for medical services may be either personal or non-personal in nature. Personal services contracts are characterized by an employer-employee relationship between the Government and the contract health care provider. DoD Instruction 6025.5, "Personal Services Contracts (PSCs) for Health Care Providers (HCPs)," January 6, 1995, states a personal services contract is the preferred method to use when hiring health care providers. Personal services contracts are generally less expensive than non-personal services contracts because the Government assumes the risk of medical malpractice. In a medical setting, according to the instruction, the direction and supervision of contractors is an assumption of liability, and the Government will provide legal representation for medical malpractice claims brought against a contractor working under such circumstances.

Non-personal services contracts should not be used to avoid the lack of a contracting officer's authority to enter into personal services contracts when personal services are to be provided. According to the NMLC legal counsel, only a contract properly awarded under section 1091, title 10, United States Code (10 U.S.C. 1091) can trigger the malpractice protection provided under 10 U.S.C. 1089. Thus, a contract awarded for non-personal services but administered as a personal services contract exposes the Government to unnecessary risk, because the contract may be unenforceable if it creates an employer-employee relationship between the Government and the contract health care provider. Further, under such circumstances, the Government may be

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reimbursing the contractor for carrying unneeded malpractice insurance because the contractor's bid likely reflects that expense.

It appears that the Military Departments awarded contracts as personal or non-personal based on the contracting authority of the issuing office and timeliness rather than the true nature of the work. Although the Army and the Navy predominately used personal services contracts appropriately, the Air Force used non-personal services contracts almost exclusively for all types of medical services because the Veterans Affairs office that provides the majority of contractual support did not have the authority to issue personal services contracts for DoD. Additionally, at one Navy MTF visited, non-personal services contracts for non-TRICARE medical services were awarded through the Federal supply schedule because MTF personnel responsible for those contracts believed that was the quickest way to acquire the services at year's end. Further, out of 31 non-personal services contract action awards reviewed, there were 12 that we believe should have been personal services contracts because there was an employer-employee relationship between the Government and the contract health care provider.

We believe that OASD(HA) and the Military Departments need to issue additional guidance clarifying the proper use of personal and non-personal services contracts and need to strengthen oversight to ensure personal services contracts are used when appropriate. The President's Management Agenda contains a specific program initiative to improve sharing between DoD and the Department of Veterans Affairs, and we believe incompatible contracting authority is a barrier to sharing. DoD and the Department of Veterans Affairs established a Joint Executive Council, which is co-chaired by the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of Veterans Affairs. To improve sharing, we believe the DoD/Department of Veterans Affairs Joint Executive Council should consider solutions to barriers caused by the Department of Veterans Affairs' inability to award personal services contracts for DoD.

**Forward Funding Contractual Work.** MTFs liberally interpreted forward funding guidance and related principles of Federal appropriation law. We based that conclusion on results from our prior audit (Inspector General of the Department of Defense [IG DoD] Report No. D-2003-113, "Franchise Business Activity Contracts for Medical Services," June 30, 2003) and discussions with contracting personnel in the Military Health System. Forward funding is authorized by 10 U.S.C. 2410, which allows for the use of annual DoD appropriations beyond the end of the fiscal year for a contract of severable services entered into during the current year, provided the contract does not exceed 12 months in duration. Principles of appropriation law provide that services should generally be charged to the appropriation current at the time the services are rendered.

As discussed in IG DoD Report No. D-2003-113, MTFs used the Department of the Treasury Franchise Business Activity (FBA) to acquire health care services, potentially forward funding health care services contracts. For instance, an Army MTF visited during that review used FY 2002 funds to request task orders for medical services totaling about \$400,000, with a projected work start date of

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September 30, 2002. Army Audit Agency Report No. A-2002-0562-IMH, "Management Controls for Reimbursable Orders, U.S. Army Garrison Fort Sam Houston," September 16, 2002, describes how an Army MTF used an FBA contract to spend appropriated funds from one year for obligations in subsequent years. We believe that the exception to forward funding in 10 U.S.C. 2410 does not apply to medical services acquired through franchise funds because the statute only applies to contracts awarded by DoD. DoD used the FBA through a memorandum of understanding between the FBA and the MTF. The actual contract was between the FBA and the health care provider. Thus, the forward funding statute would not apply to medical services acquired through the FBA by DoD. Further, in response to IG DoD Report No. D-2003-113, the Office of General Counsel, TRICARE Management Activity, in conjunction with the Office of General Counsel, DoD, stated that "although the FBA may use its fund without fiscal year limitation under its enabling statute, use of the fund does not change the period of availability of the customer agency's (DoD's) appropriation."

In addition to the FBA forward funding issue discussed in the prior report, we found other examples of year-end procurement of medical services that provide the appearance of inappropriate use of the statute. Although we recognize that the timing of funding releases are not within the control of the MTFs, we believe that OASD(HA) and the Military Departments need to issue guidance concerning the use of the forward funding statute to acquire medical services and monitor the use of the statute.

**Minimum Guarantees in Contracts.** The Army and the Navy used different approaches on how to award minimum guaranteed work required under MATO contracts.<sup>4</sup> Through discussions with contracting officials at HCAA and NMLC (the two medical contracting organizations issuing MATOs for medical services) and through review of three MATO contracts, we determined that the Army and the Navy handled the awarding of minimum guaranteed work in significantly different ways.

On the two iMAP MATO contracts, the Army awarded a small minimum guaranteed order (\$10,000 to \$15,000) per contractor. The amount was arrived at by estimating the profit a contractor would receive on the average value of an Army task order or contract for similar services based on historical data. A task order was funded in the amount of the guaranteed minimum and issued at the time of contract award. Throughout the year, all contractors competed for task orders. At the point in time when the contractor received a competitive award of a task order, the minimum guarantee was considered to have been met and the original task order for the guaranteed minimum was cancelled. The guaranteed minimum amount was only paid if a contractor did not receive any work through the contract. The HCAA considered the approach to be reasonable, because it managed cost risk associated with the guaranteed minimums while increasing competition.

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<sup>4</sup> To make MATO contracts legally binding, each contractor is to receive a guaranteed minimum amount of work. See Appendix C for further explanation of MATO contracts.

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According to NMLC officials, rather than waiting to the end of the contract to pay for guaranteed minimum work, NMLC awarded large minimums up front. We examined one large Navy MATO contract. The Navy had issued guaranteed minimums through initial task orders, totaling about \$5.8 million, to five contractors. NMLC awarded each contractor from \$700,000 to \$2.2 million of work without providing each contractor a fair opportunity to bid on those initial task orders in accordance with Federal Acquisition Regulation (FAR) Subpart 16.505, "Ordering." All five contractors were subsequently awarded a logical follow-on task order non-competitively.

FAR Subpart 16.505 permits awards based on minimums, but does not specify when to award the minimum. According to IG DoD Report No. D-2001-189, "Multiple Award Contracts for Services," September 30, 2001, a prudent business practice would be to award those minimums only when the contract period is nearing completion and the contractor has not yet been awarded a task order. Although awarding the large task orders immediately after awarding the contract might not have violated the FAR, it might not have resulted in the best value (quality and price) to DoD and the Government because the MATO contractors were not provided a fair opportunity to bid on each task order.<sup>5</sup> Further, the lack of competition might have been continued through the award of the logical follow-on task orders. FAR Subpart 16.505 generally exempts logical follow-on task orders from competition; however, FAR Subpart 16.505 states that all vendors must have been provided a fair opportunity to bid on the original task order to exempt a logical follow-on task order from competition. Consequently, we believe that OASD(HA) and the Military Departments need to strengthen guidance stating how contracting offices should award minimum guaranteed work and logical follow-on task orders for MATO contracts to ensure that DoD and the Government achieve best value through maximum competition.

**Use of Individual Set-Aside Contracts.** MTFs were using ISA contracts (which are contracts with individual health care providers) to acquire the services of health care professionals in instances when it may not have been the most effective contracting method. Based on discussions with Military Health System contracting officials and through reviews of selected contract actions, we believe that MTF personnel were not fully aware of the consequences of using ISAs. HCAA, NMLC, and six MTFs visited used ISA contracts to acquire the services of health care professionals. We believe ISA contracts should only be used after consideration of cost impacts. According to an Army Medical Contracting Command information paper on using contracts with individual health care providers, administrative costs to consider when determining whether an ISA contract is appropriate include effort required to recruit, credential, relocate, train, pay (including fringe benefits and tax considerations), document, supervise, assess, and schedule. When the Government awards a contract to a company for an individual or individuals to work under the contract, the company is responsible for those administrative tasks. Further, ISA contracts do not allow for replacements. Contracting with individual health care professionals requires that a separate contract be awarded each time a health care professional is needed, whereas a contract with a company provides for replacements without having to

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<sup>5</sup> Each task order of a MATO contract is competed among a pool of pre-qualified vendors. See Appendix C for further explanation of MATO contracts.



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issue another contract. Another potential problem is the pre-selection of individuals for contractual work. At one Army MTF visited, we found numerous indicators that contractors were potentially pre-selected for the 12 ISA contracts we selected for review, including:

- 10 of the 12 were awarded to the source suggested by the requestor;
- 9 of 12 bids were within \$5 of the Government estimate;
- 6 of 12 received 2 or fewer bids;
- 6 of 12 winning bidders had prior experience working at the MTF;
- 5 of 12 contract files had no documentation of a technical evaluation; and
- 4 of 12 contract files lacked documentation of contract advertisement.

We recognize that ISA contracts may be appropriate in certain circumstances, such as acquiring a scarce specialty or filling vacancies in remote markets. Further, we recognize that there are some costs (such as general and administrative expenses) that are not included in ISA contracts.

Although the HCAA and NMLC were fully aware of and appeared to use ISA contracts only when appropriate, MTFs needed additional guidance on using ISA contracts. In addition to the administrative costs, ISA contracts may impose a financial liability on the Government. In August 2002, the Internal Revenue Service ruled that a dental hygienist engaged by the Navy through an ISA contract was in fact an employee, not a contractor; therefore, the amounts paid to the individual were wages and subject to federal employment taxes and income withholding. According to the ruling, any individual engaged by the Navy under similar circumstances was also to be considered an employee, not a contractor. According to Navy and Defense Financial and Accounting Service San Diego officials, DoD had not paid any Federal Insurance Contributions Act (FICA) taxes for the dental hygienist or any other health care worker hired through similar ISA contracts. Defense Financial and Accounting Service officials stated that they do not have the mechanism to make such payments and Defense Financial and Accounting Service pays individuals based on the terms of the contracts. The Internal Revenue Service ruling could have an impact on Government financial statements and Defense Financial and Accounting Service workload. Until this issue is resolved, we believe that the Military Health System should reduce potential liability by limiting the use of ISA contracts. With the aid of personnel from the Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics (OUSD[AT&L]), we identified 756 contracts in DCADS that listed an individual's name as the contractor (2002 data). If the Internal Revenue Service ruling applied to all 756 contracts, the 2002 FICA liability of DoD could be about \$2.5 million.

OASD(HA) and the Military Departments need to issue appropriate guidance concerning the use of ISA contracts and provide oversight to ensure that MTFs

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and medical contracting personnel are made aware of cost considerations, the limited flexibility that the contracts provide regarding replacement personnel, and the potential for limiting competition.

**Competition.** Acquisitions for non-TRICARE medical services indicate a need for oversight of the adequacy of the competition achieved. With the assistance of personnel from the Directorate for Information Operations and Reports, Washington Headquarters Services, we examined DCADS data for 2002 and found that 50 percent of the non-TRICARE medical services contract actions, excluding sole-source actions, obligations, deobligations, modifications, and logical follow-ons, received only one bid, as shown in the following table.

**2002 Medical Services Contractual Actions With One Bid**

	<u>Contract Actions</u>	<u>Actions With One Bid</u>	<u>Percent</u>
Army	455	254	56
Navy	454	200	44
Air Force	63	33	52
<b>Total</b>	<b>972</b>	<b>487</b>	<b>50</b>

We were unable to evaluate the extent to which those actions were competed because the data can only be validated by reviewing each and every contract file. Consequently, we recognize that the data may include valid instances of market conditions that resulted in the receipt of only one offer even though more than one contractor was solicited. Although the data alone was not conclusive evidence that a problem exists, it was certainly an indicator supporting the need for further management attention. Discussions with Military Health System contracting officials and a review of selected contract actions showed examples where competition could have been improved without curtailing health care services provided to beneficiaries. For example, one MTF received only one bid for a geneticist position that it advertised for only 2 days in the local newspaper with a circulation of only 150,000. Although the advertisement satisfied Defense Federal Acquisition Supplement Subpart 237.104, "Personal Services Contracts," we believe advertising in a neighboring city's newspaper that had a circulation more than 3 times that of the local paper could have provided more robust competition. In another example, the technical evaluation for a contract for optometry services included a requirement for the vendor to have had 3 years of active duty experience. As a result, only one vendor was deemed qualified. Moreover, as mentioned earlier in this report, half of the contracts reviewed (6 of 12 contracts) at another Army MTF received fewer than 3 bids and often (10 of 12 times) were awarded to the suggested source. Additionally, the NMLC practice of awarding large minimum guarantees as initial task orders for MATO contracts, in combination with award of logical follow-on task orders, can also

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limit competition. Although we were not able to fully evaluate the extent each contract action was competed, the DCADS competition percentages and examples of limited competition of ISA contracts and MATO task orders indicate a need for improved oversight of competition for non-TRICARE medical services contracts.

## Strategic Approach

The Military Health System could improve the effectiveness and consistency of contracting for non-TRICARE medical services by developing an acquisition strategy and better coordinating its contracting efforts. The DoD approach to acquiring non-TRICARE medical services is inconsistent and fragmented. While we recognize that MTFs should have the ability to satisfy their medical services needs locally, we believe there needs to be greater sharing of contracting resources and stronger guidance and oversight to ensure efficient use of non-TRICARE medical services contracts in accordance with applicable Federal laws and regulations. Spending on non-TRICARE medical services are expected to exceed \$1 billion annually as a result of workload increases caused by converting various TRICARE services to non-TRICARE contracts.<sup>6</sup> The sharing of contracting resources among the Military Departments should provide for greater contracting capacity which would help absorb workload increases.

Our concerns over the lack of an acquisition strategy are consistent with the position taken by the General Accounting Office (GAO) regarding DoD services contracts in two recent reports. Both GAO Report No. GAO-03-661, "Best Practices: Improved Knowledge of DoD Service Contracts Could Reveal Significant Savings," June 2003, and GAO Report No. GAO-03-935, "Contract Management: High-Level Attention Needed to Transform DoD Services Acquisition," September 2003, recognize that DoD is not moving quickly toward a strategy for acquiring services. GAO reported that DoD was only in the beginning stages of a procurement study for services acquisitions and that the DoD management structure in place for acquiring services only required reviews of individual acquisitions valued at more than \$500 million.

**Procurement Study.** We believe that the development of an acquisition strategy is consistent with ongoing OUSD(AT&L) efforts to improve services contracting. On February 6, 2003, the Deputy Secretary of Defense tasked OUSD(AT&L) to perform a spend analysis of DoD-purchased services. Out of 52 subcategories of services spending, the analysis identified 10 as attractive for new procurement strategies, of which 5 were selected for the development and execution of new procurement strategies, referred to as pilot programs. Medical services accounted for 3 of the 52 subcategories, but none were selected as attractive for new procurement strategies. Considering that spending on non-TRICARE medical services is expected to exceed \$1 billion annually, we believe that the Under Secretary of Defense for Personnel and Readiness should request that OUSD(AT&L) establish a pilot program for non-TRICARE medical services. If

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<sup>6</sup> The Military Departments estimated an increased workload in contracting valued at \$358 million for FY 2005 from the conversion of various services from TRICARE to non-TRICARE contracts under the next generation of TRICARE contracts.

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establishing such a pilot program is not possible as part of the OUSD(AT&L) effort, OASD(HA) needs to conduct an analysis similar to the pilot program review.

**Centers of Excellence.** The acquisition strategy for non-TRICARE medical services should include the implementation of the centers of excellence concept. IG DoD Report No. D-2000-100, “Contracts for Professional, Administrative, and Management Support Services,” March 10, 2000, recommended, and DoD agreed, that centers of excellence with knowledgeable buyers for specific services be established, rather than relying on every contracting officer to be an expert on multiple markets or multiple suppliers within one market. Additionally, Public Law 106-398, “National Defense Authorization Act for FY 2001,” October 30, 2000, required the Secretary of each Military Department to establish at least one center of excellence in contracting for services.<sup>7</sup> The Army designated HCAA as the center of excellence for health care acquisition. No other action was taken by the Military Departments or OASD(HA) to implement the centers of excellence concept as it relates to acquiring non-TRICARE medical services. However, the Navy stated that although not formally designated as such, NMLC is acting in the capacity of a center of excellence. OASD(HA) and the Military Departments should include the centers of excellence concept in a DoD strategy for the acquisition of non-TRICARE medical services. There are different ways the concept could be implemented. For example, each Military Department could be appointed as the center of excellence for certain categories of medical services, such as ancillary services, physician services, or laboratory testing services. That would permit each Military Department to maintain its own contracting organizations to ensure its MTFs are supported, yet provide a focal point for best practices and inter-Military Department contracts for specific types of medical services acquisitions.

## Guidance and Oversight

In addition to developing a strategy, the Military Health System needs additional acquisition guidance and oversight. According to OASD(HA) officials, they do not monitor nor provide policy or procedures regarding the acquisition of non-TRICARE medical services. However, DoD Directive 5136.1, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” May 27, 1994, states that OASD(HA) provides policy and procedures for DoD medical programs. Further, DoD Instruction 6025.5 requires that OASD(HA) monitor Military Department use of personal services contracts to ensure that it is cost-effective when compared to other methods, such as TRICARE or conversion to either military or civilian staff billets. Neither OASD(HA) nor the Military Departments were fully monitoring the acquisition of non-TRICARE medical services. Although Military Department medical contracting officials were generally aware of contracting actions issued through their medical contracting offices, such as HCAA and NMLC, none of the Military Departments monitored contracting actions taken at the MTF or base level. The Navy’s Bureau of Medicine and Surgery Instruction

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<sup>7</sup> The Act states each center of excellence shall assist the acquisition community by identifying and serving as a clearinghouse for best practices in contracting for services in the public and private sectors.

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4200.2A, “Healthcare Contracting” (draft), provides guidance on the use of personal and non-personal services contracts, the FBA, and ISA contracts; however, the Instruction has been in draft since at least May of 2002. OASD(HA) and the Military Departments need to improve oversight for medical services acquisitions and strengthen guidance to ensure, at a minimum, that the most appropriate contracting methods are used, that appropriation law is implemented properly and consistently, that MATO contracts are used consistently and effectively, and that competition is achieved to the maximum extent practicable.

## **Conclusion**

Although DoD and the Military Departments had taken action to improve the acquisition of non-TRICARE medical services, additional attention was needed to ensure that MTFs are able to satisfy requirements quickly and in the most effective manner. By developing an acquisition strategy for non-TRICARE medical services and better coordinating contracting efforts, the Military Health System could:

- reduce duplication and fragmentation among DoD contracting organizations that acquire medical services;
- reduce exposure to risk from non-personal services contracts administered as personal services contracts;
- increase competition in contracting; and
- avoid a potential FICA liability, which may be incurred by the use of ISA contracts.

In addition, due to the lack of uniformity regarding the use of FBA contracts to forward fund appropriations from one fiscal year for work performed in the next fiscal year, we believe that clarifying guidance would be appropriate. Although we have cited examples where medical services contracting could have been improved, nothing in this report should be interpreted as though the Military Health System has not provided quality health care to its beneficiaries.

## **Management Comments on the Finding and Audit Response**

The Assistant Secretary of Defense (Health Affairs) commented that the legislative relief granted to DoD in 10 U.S.C. 2410a to permit the funding of severable services to cross fiscal years is not premised on whether the period of performance is within the control of the agency. As a result, we revised our posture on the Navy’s interpretation of the forward funding statute and modified the report to reflect that.

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## Recommendations, Management Comments, and Audit Response

**Revised Recommendations.** In response to management comments, we revised the terminology from “non-TRICARE medical services” to “direct care medical services” in Recommendations 2., 5., and 6., in the report title and finding title, and in the executive summary.

**1. We recommend that the Under Secretary of Defense for Personnel and Readiness, as co-chair of the DoD/Department of Veterans Affairs Joint Executive Council, review potential solutions to barriers of DoD and Department of Veterans Affairs sharing caused by incompatible statutory authority to award personal services contracts.**

**Under Secretary Comments.** The Under Secretary of Defense for Personnel and Readiness did not comment on the recommendation.

**Air Force Surgeon General Comments.** Although not required to comment, the Office of the Air Force Surgeon General agreed with the recommendation and stated the current lack of statutory authority of the Department of Veterans Affairs to award personal services contracts for Air Force MTFs creates a potential barrier to the award of appropriate contracts. Further, the Air Force commented that extending the DoD personal services contracting authority to the Department of Veterans Affairs would promote DoD and Department of Veterans Affairs sharing initiatives.

**Audit Response.** We request that the Under Secretary of Defense for Personnel and Readiness provide comments in response to the final report.

**2. We recommend that the Under Secretary of Defense for Personnel and Readiness request that the Under Secretary of Defense for Acquisition, Technology, and Logistics establish a pilot program for acquiring direct care medical services.**

**Under Secretary Comments.** Although the Under Secretary of Defense for Personnel and Readiness did not comment on the recommendation, comments provided by the Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics satisfy the intent of the recommendation.

Although not required to comment, the Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics agreed with the recommendation and has initiated coordination with the Assistant Secretary of Defense (Health Affairs). The planned course of action is to name a Military Department executive agent to be responsible for establishing a commodity team comprised of representatives from each Military Department. The commodity team will be tasked with developing an acquisition strategy for direct care medical services and recommending a pilot program based on that strategy.

**Air Force Surgeon General Comments.** Although not required to comment, the Office of the Air Force Surgeon General agreed with the recommendation and

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stated that the pilot program effort should include input from the Services and the Department of Veterans Affairs. The Air Force cited success in implementing improvements in acquiring medical equipment through a similar effort.

**3. We recommend that the Assistant Secretary of Defense (Health Affairs) request a legal review concerning Federal Insurance Contributions Act tax for individual set-aside contracts.**

**Management Comments.** The Assistant Secretary of Defense (Health Affairs) concurred.

**4. We recommend that if the legal review requested in Recommendation 3. determines that individual set-aside contracts are subject to Federal Insurance Contributions Act tax, that the Under Secretary of Defense (Comptroller)/Chief Financial Officer:**

**a. Develop a process for future payments of Federal Insurance Contributions Act tax for individual set-aside contracts.**

**b. Direct fund holders who did not pay the required Federal Insurance Contributions Act tax to determine the existence of a liability and to make the necessary accounting entries for Government financial statements.**

**Under Secretary Comments.** The Acting Under Secretary of Defense (Comptroller)/Chief Financial Officer concurred and stated that after the legal opinion from Recommendation 3., the Office of the Under Secretary will address the required changes for withholding FICA and other payroll taxes in its Business Modernization System Integration effort. Further, the Acting Under Secretary stated that he will direct the appropriate fund holders to determine the existence of FICA liabilities, make the required employee withholding for FICA taxes, and make all required adjustments to the financial statements.

**Assistant Secretary of Defense (Health Affairs) Comments.** Although not required to comment, the Assistant Secretary of Defense (Health Affairs) agreed with the recommendation.

**5. We recommend that the Assistant Secretary of Defense (Health Affairs), in conjunction with the Military Department Surgeons General:**

**a. Develop a coordinated strategy for acquiring direct care medical services that includes the implementation of the centers of excellence concept.**

**b. Develop implementing guidance for acquiring direct care medical services. At a minimum, issue guidance on:**

- (1) The use of personal versus non-personal services contracts.**
- (2) The appropriate use of forward funding.**

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**(3) The fulfillment of minimum guarantees for multiple award task order contracts.**

**(4) The use of individual set-aside contracts.**

**Assistant Secretary of Defense (Health Affairs) Comments.** The Assistant Secretary of Defense (Health Affairs) concurred.

**Air Force Surgeon General Comments.** Although not required to comment, the Office of the Air Force Surgeon General agreed with Recommendations 5.a., 5.b.(1), 5.b.(3), and 5.b.(4) and disagreed with Recommendation 5.b.(2). The Air Force agreed with the center of excellence concept and has begun to establish a center of excellence specifically for medical acquisition at Wright-Patterson Air Force Base. Further, the Air Force has already made changes to Air Force guidance requiring coordination through the Services' designated official for planned acquisitions with non-DoD agencies. The Office of the Air Force Surgeon General also agreed that establishment of implementing guidance on the appropriate use of forward funding and use of ISAs would be helpful and stated that the timing for the release of funding for medical services acquisitions needs to be addressed in order to permit procurement personnel to timely establish medical services contracts.

**Audit Response.** We understand the Air Force concerns regarding funding release issues; however, timing of appropriations was outside of the scope of our audit.

**6. We recommend that the Military Department Surgeons General develop an oversight process for the acquisition of direct care medical services, to include, at a minimum, monitoring:**

**a. The type and character of contracts used.**

**b. The use of the forward funding statute.**

**c. The award of minimum guarantees for multiple award task order contracts.**

**d. The extent of contract competition.**

**Assistant Secretary of Defense (Health Affairs) Comments.** The Assistant Secretary of Defense (Health Affairs) concurred.

**Army Surgeon General Comments.** The Deputy Surgeon General of the Army concurred. The Army intends to include the elements of the recommendation in its Procurement Management Review Program beginning September 30, 2004.

**Navy Surgeon General Comments.** The Navy Surgeon General did not comment on the recommendation.

**Air Force Surgeon General Comments.** The Office of the Air Force Surgeon General concurred. The Office of the Air Force Surgeon General stated that an



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oversight process for acquiring non-TRICARE medical services should include the Assistant Secretary of the Air Force (Acquisition), which has the primary responsibility for services acquisition contracting. Additionally, the Office of the Air Force Surgeon General stated that the Air Force Medical Service should identify requirements and, in conjunction with the other Services and the Department of Veterans Affairs, develop an overall strategy for acquiring non-TRICARE medical services. Further, the Office of the Air Force Surgeon General stated that in developing an oversight process, the newly formed Air Force Medical Service Commodity Council should collaborate with the medical acquisition center of excellence at Wright-Patterson Air Force Base, the Assistant Secretary of the Air Force (Acquisition), the Air Force Surgeon General, and the Tri-Service Medical Contracting Working Group.

**Audit Response.** We request that the Navy Surgeon General provide comments in response to the final report.

## **Management Comments on the Management Control Program**

The Assistant Secretary of Defense (Health Affairs) disagreed with our assessment of the management control program. The Assistant Secretary states that the findings in this report do not constitute a material management control weakness and states that adequate oversight is provided by the Military Departments. In order to strengthen the management control program, the Assistant Secretary plans to initiate a new assessable unit for the Defense Health Program that addresses the topic of acquiring direct care medical services. The Assistant Secretary indicated supplemental guidance would be issued to the FY 2004 management control program guidance previously released to the Military Departments.

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## Appendix A. Scope and Methodology

We reviewed public laws, the FAR, and DoD and Military Department regulations relating to the acquisition of medical services. We also downloaded DCADS data from the Web and queried for contract actions reported under Federal supply code Q (medical services). Using DCADS data for 2000 through 2003, we identified initial locations to visit based on the total amount of non-TRICARE medical services (non-information technology) acquired and the types of contracts used to acquire them. We also identified information in DCADS that could have been used by the Military Departments and OASD(HA) to manage those acquisitions, including identification of overlapping contracts. Using DCADS, we identified Army and Navy contracts for the same Federal supply code classification in the same geographic area, but did not review detailed statements of work for those contracts. We visited the office within each Military Department that was delegated the responsibility for medical services acquisitions by each respective Surgeon General. Additional sites were judgmentally selected to include MTFs from each Military Department, both large and small, and those organizations that were involved in issues raised during the audit. To gain an understanding of how DoD medical facilities acquire medical services and to determine what guidance and controls exist regarding the procurement of those services, we visited and held discussions with personnel from:

- Army Medical Command, San Antonio, Texas;
- HCAA, San Antonio, Texas;
- NMLC, Fort Detrick, Maryland;
- Air Force Medical Logistics Office, Fort Detrick, Maryland;
- FISC San Diego, California;
- FISC Norfolk, Detachment Philadelphia, Pennsylvania;
- Brooke Army Medical Center, San Antonio, Texas;
- Madigan Army Medical Center, Tacoma, Washington;
- McDonald Army Community Hospital, Newport News, Virginia;
- Walter Reed Army Medical Center, Washington, D.C;
- Naval Medical Center San Diego, California;
- Naval Medical Center Portsmouth, Virginia;
- 62nd Medical Group, McChord Air Force Base, Tacoma, Washington;  
and
- Wilford Hall Medical Center, San Antonio, Texas.

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To determine the extent of DoD-wide coordination of medical services contracting, we met with officials from OUSD(AT&L), OASD(HA), and the Offices of the Surgeons General of the Military Departments.

We examined documentation pertaining to 125 contract actions (Federal Supply Code Q) that were used by the Military Departments during FY 2000 through FY 2003 to acquire medical services, valued at about \$73 million. We did not select the 125 contract actions prior to our site visits. Rather, we judgmentally selected the contract actions based on issues that we identified at each site through discussions with Military Health System officials and through reviews of contract actions reported in DCADS. The documents in our review were dated from May 1995 through October 2003. Initially, we reviewed documentation supporting contract actions awarded for medical services to determine whether contracting officials were following prescribed procedures for awarding and managing the contracts. However, we shifted our focus during the course of the audit to the approaches used by the Military Departments at different organizational levels of contracting to acquire non-TRICARE medical services. As a result, we did not review the same issues at each location visited. Although we identified issues that affected competition in contracting, we were not able to fully evaluate whether competition was achieved on every contract action reviewed because all related supporting documents were not readily available. We assessed appropriateness of acquisition methodologies. We did not review the validity of contract payments made by DoD medical facilities for non-TRICARE medical services. To estimate the potential Government liability for FICA applicable to ISA contracts awarded in 2002, we obtained a listing of DCADS contracts listing an individual's name as the contractor and applied a 7.65 percent tax to the total contract values. We performed phase one of this audit from April 2002 to May 2003, which resulted in IG DoD Report No. D-2003-113. We performed this audit from May 2003 through March 2004 in accordance with generally accepted government auditing standards.

**Use of Computer-Processed Data.** With assistance from the Directorate for Information Operations and Reports, Washington Headquarters Services, we used DCADS to determine the scope of medical contracting for supplemental (non-TRICARE) medical care. Although DCADS is the most comprehensive system within DoD for accumulating contract actions, data reliability is questionable. In GAO Report No. 03-1068, "Contract Management: No Reliable Data to Measure Benefits of the Simplified Acquisition Test Program," September 2003, GAO reported significant data reporting errors in DCADS. During the course of this audit and the previous audit (IG DoD Report No. D-2003-113), we identified that DoD contract actions for non-TRICARE medical services with non-DoD agencies are not included in DCADS. Although we relied on the reporting system to estimate the scope of non-TRICARE medical services contract dollars and provide competition data for non-TRICARE medical services contract actions, we did not validate its reliability because it did not affect the overall audit conclusions.

**GAO High-Risk Area.** GAO has identified several high-risk areas in DoD. This report provides coverage of the DoD Contract Management and the DoD Support Infrastructure Management high-risk areas.

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## Management Control Program Review

DoD Directive 5010.38, "Management Control (MC) Program," August 26, 1996, and DoD Instruction 5010.40, "Management Control (MC) Program Procedures," August 28, 1996, require DoD organizations to implement a comprehensive system of management controls that provides reasonable assurance that programs are operating as intended and to evaluate the adequacy of the controls.

**Scope of the Review of the Management Control Program.** We reviewed management control procedures related to contract actions awarded for non-TRICARE medical services (Federal Supply Code Q). We specifically reviewed appropriateness of contract type and acquisition methodology. We reviewed management's self-evaluation applicable to those controls.

**Adequacy of Management Controls.** We identified material management control weaknesses for the Military Departments and OASD(HA) as defined by DoD Instruction 5010.40. Military Department and OASD(HA) management controls were inadequate to ensure that DoD acquired non-TRICARE medical services in the most effective manner. Recommendations 2., 4.a., 5., and 6., if implemented, will improve procedures that the Military Departments and OASD(HA) use for awarding and managing contracts. A copy of the report will be provided to the senior official responsible for management controls within the Military Departments and the OASD(HA).

**Adequacy of Management's Self-Evaluation.** The Army did not identify the material management control weaknesses identified by this audit because the Army only recently established HCAA as an assessable unit and did not conduct all scheduled procurement management reviews during FY 2002. However, as the Army HCAA management control program matures, medical services contracting efforts will be subject to additional oversight. The Air Force defined assessable units related to the acquisition of non-TRICARE medical services too broadly to identify or report the material management control weaknesses identified by the audit. The Navy did not define procurement of non-TRICARE medical services as an assessable unit in its FY 2002 management control program and, accordingly, did not identify the material management control weaknesses cited in this report.

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## Appendix B. Prior Coverage

During the last 5 years, the GAO, the IG DoD, and the Army Audit Agency have issued eight reports related to contracting for services. Unrestricted GAO reports can be accessed over the Internet at <http://www.gao.gov>. Unrestricted IG DoD reports can be accessed at <http://www.dodig.osd.mil/audit/reports>. Army reports can be accessed over the Internet at <https://www.aaa.army.mil> from certain domains.

### GAO

GAO Report No. GAO-03-935, “Contract Management: High-Level Attention Needed to Transform DoD Services Acquisition,” September 2003

GAO Report No. GAO-03-1068, “Contract Management: No Reliable Data to Measure Benefits of the Simplified Acquisition Test Program,” September 2003

GAO Report No. GAO-03-661, “Best Practices: Improved Knowledge of DoD Service Contracts Could Reveal Significant Savings,” June 2003

### IG DoD

IG DoD Report No. D-2004-015, “Contracts for Professional, Administrative, and Management Support Services,” October 30, 2003

IG DoD Report No. D-2003-113, “Franchise Business Activity Contracts for Medical Services,” June 30, 2003

IG DoD Report No. D-2001-189, “Multiple Award Contracts for Services,” September 30, 2001

IG DoD Report No. D-2000-100, “Contracts for Professional, Administrative, and Management Support Services,” March 10, 2000

### Army Audit Agency

Army Audit Agency Report No. A-2002-0562-IMH, “Management Controls for Reimbursable Orders, U.S. Army Garrison Fort Sam Houston,” September 16, 2002

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## Appendix C. Contractual Methods

### Character of Contract Services

Contracts for medical services may be characterized as personal or non-personal in nature and acquired through many different contract types. FAR Part 37, “Service Contracting,” provides a detailed description of personal and non-personal services contracts.

**Personal Services Contracts.** Personal services contracts are characterized in FAR Part 37 as establishing an employer-employee relationship between the Government and the contract health care professional. The Secretary of Defense is authorized under 10 U.S.C. 1091 to enter into personal services contracts for clinical health care providers. DoD Instruction 6025.5, “Personal Services Contracts for Health Care Providers,” January 6, 1995, states that personal services contracts are the preferred method of contracting for health care providers who are subject to the direction and supervision of the Government. According to the Instruction, in a medical setting, the direction and supervision of contract personnel is an assumption of liability, and the Government provides legal representation for medical malpractice claims brought against a contractor working under such circumstances. FAR Subpart 37.104, “Personal Services Contracts,” provides the following elements to aid in determining whether a contract is personal in nature:

- contract performance is on site;
- equipment for contract performance is provided by the Government;
- contract performance applies directly to the organizational function or mission;
- services provided under the contract are also provided by civilian Government employees;
- the need for the services can be reasonably expected to last beyond 1 year; or
- the nature of the services, or the manner in which the services are provided, require Government direction or supervision.

**Non-Personal Services Contracts.** Per FAR Subpart 37.101, “Definitions,” a health care professional contracted under a non-personal services contract is not subject, by either the contract terms or the manner of administration, to the supervision and control of the Government. Rather, the contractor is supervised by the company with which the Government contracted for the services. Thus, non-personal services contracts are most appropriate when the services may be segregated within the facility and the contractor is responsible for providing an entire service or function (such as a complete emergency room or optometry clinic). In such instances, FAR Subpart 37.401, “Policy,” states that the

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contractor must indemnify the Government against legal action alleging malpractice by non-personal services contract health care professionals. Contracting experts that we interviewed indicated non-personal services contracts for health care professionals usually cost more than personal services contracts because the contractor's cost of malpractice insurance is passed on to the Government in the contract price.

## Contract Types

There are a variety of types of contracts available to MTFs to fulfill medical needs not met by TRICARE. The following paragraphs describe selected contract types used at the locations visited during the audit.

**Individual Set-Aside Contracts.** An ISA is a firm-fixed-price contract made directly with the health care professional in accordance with FAR Subpart 13, "Simplified Acquisition Procedures." ISAs can usually be put in place in less than 140 days.

**Multiple Award Task Order Contracts.** FAR Subpart 16.5, "Indefinite-Delivery Contracts," describes a MATO contract as an indefinite-delivery contract awarded to two or more contractors that typically contains minimum and maximum levels of services the Government plans to order from the contractors. Individual task orders are competed on the basis of price or past performance and, in some cases, technical merit and timeliness. Services performed under MATO contracts may be personal or non-personal. It takes about 9 months to award a complex MATO; once in place, individual task orders can be issued within about 60 days.

**General Services Administration and Department of Veterans Affairs Schedules.** The General Services Administration's Federal supply schedule provides the Government with a simplified process for acquiring goods and services through eight active schedules for medical products and services. The General Services Administration determines prices to be fair and reasonable prior to placing them on the schedule. It is incumbent upon ordering officers to negotiate prices using available discounts. The Air Force Medical Logistics Office acquires medical services through a fee-for-service agreement with the Department of Veterans Affairs, through delegation of General Services Administration's statutory authority. The Department of Veterans Affairs is delegated statutory authority to administer the Federal supply schedule as it relates to health care. The Department of Veterans Affairs charges a surcharge ranging from 1 percent to 2 percent of the order. The Department of Veterans Affairs does not have personal services contracting authority, so all medical services acquired through the agreement must be through non-personal services contracts. According to Air Force Medical Logistics Office personnel, Air Force orders for medical services were typically filled within 11 days.

**Franchise Business Activity Contracts.** As part of the franchise fund program, the Department of the Treasury created the FBA to provide Federal organizations common financial and administrative support services on a reimbursable basis. To acquire medical services using an FBA contract, MTFs enter into an

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interagency agreement with the FBA and place purchase calls or task orders against existing contracts between the FBA and a vendor. According to FBA officials, the surcharge for using its services varies by task order from 2 percent to 10 percent of the individual task order. The Department of the Treasury does not have personal services contracting authority, so all medical services acquired through the FBA must be through non-personal services contracts. According to MTF personnel, contractors can be obtained in as few as 2 to 3 days once an interagency agreement is in place.



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## Appendix D. Summary of Recent Legislation on DoD Services Contracts

The National Defense Authorization Acts for FYs 2001 and 2002 included specific provisions addressing DoD contracting for services. The legislation addresses the establishment and use of centers of excellence for acquiring services and the establishment and implementation of a management structure for the procurement of services.

**National Defense Authorization Act for FY 2001.** The National Defense Authorization Act for FY 2001 (Public Law 106-398), October 30, 2000, section 821(c), “Centers of Excellence in Service Contracting,” required that not later than 180 days after the date of the enactment of the Act, the Secretary of each Military Department establish at least one center of excellence in contracting for services. Each center of excellence was to assist the acquisition community by identifying the best practices in contracting for services in both the public and private sectors.

**National Defense Authorization Act for FY 2002.** The National Defense Authorization Act for FY 2002 (Public Law 107-107), December 28, 2001, section 801(b), “Requirement for Management Structure,” required that the Secretary of Defense establish and implement a management structure for the procurement of services for DoD. The management structure was to include a designated official for each Military Department, Defense agency, and DoD Component. The designated official would be responsible for managing the procurement of services and developing a way in which employees in Military Departments, Defense agencies, and DoD Components could be held accountable for carrying out the requirements for the procurement of services. The designated official was also responsible for establishing specific dollar thresholds and other criteria for advance approvals of purchases. The Secretary of Defense was required to establish and implement the management structure no later than 180 days after the date of the enactment of the Act. Also, the OUSD(AT&L) was required to issue management structure guidance to designated officials on how to carry out their responsibilities.

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## Appendix E. DoD and Military Department Initiatives

DoD and the Military Departments had ongoing initiatives that could improve the acquisition of non-TRICARE medical services. For example, the Army established two large contracts for medical services with worldwide coverage capability and, in response to Public Law 106-398, implemented a center of excellence specifically for medical services acquisitions. In addition, DoD issued a new 5000 series instruction; the OUSD(AT&L) performed a spend analysis of DoD contracted services; and the Military Departments formed a tri-Service working group to create a pool of non-TRICARE contracting alternatives. Most recently, the OUSD(AT&L) issued a memorandum following up on some of those service acquisition initiatives within DoD.

**iMAP.** In November 2001, the Army chartered the iMAP to improve Army processes used to acquire non-TRICARE medical services. The iMAP primarily consists of Web-based contracting tools, including two large MATO contracts, under which Army contracting officers may compete task orders among a pool of pre-qualified vendors more quickly than awarding a separate contract. The Army established two MATO contracts, one for physician services and the other for ancillary services. Those two contracts provide worldwide coverage and can be used by other Military Departments.

**Centers of Excellence.** In response to Public Law 106-398, the Army directed each of its Major Commands to establish a center of excellence for services acquisitions. The Army Medical Command reported its existing HCAA as the center of excellence for medical services acquisitions in March 2002. According to IG DoD Report No. D-2004-015, the Air Force established one center of excellence in the Office of the Deputy Assistant Secretary of the Air Force (Contracting) for all types of services acquisitions, but does not require use of the center; the Navy has not yet established any centers of excellence because of technology infrastructure changes and a departmental reorganization. However, the Navy stated that the NMLC has been acting in the capacity of a center of excellence. The NMLC sponsors a Contracting Officer Representative training course designed to provide an overview of the health care acquisition process and policy guidance.

**Spend Analysis.** On February 6, 2003, the Deputy Secretary of Defense tasked the OUSD(AT&L) to perform a spend analysis that involved a top to bottom, cross-functional analysis of procurement data in order to develop strategies necessary to conduct acquisitions as efficiently as possible. The goal of the analysis was to identify opportunities for improved efficiencies and economies in the acquisition of DoD services. The spend analysis, based on data obtained from the DCADS, was completed in August 2003. The spend analysis identified 52 subcategories of services spending, excluding research and development. Further analysis identified that 10 of those subcategories were attractive for new procurement strategies. Of the 10 subcategories, 5 were selected to be taken through the development and execution of new procurement strategies, referred to as pilot programs. Although medical services accounted for 3 of the

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52 subcategories, none of the 3 medical-related subcategories were included in the 10 selected as attractive for developing a new procurement strategy.

**Tri-Service Medical Services Contracts Working Group.** A Tri-Service Medical Services Contracts Working Group was established March 12, 2003. Chaired by the Air Force, the working group's goal is to establish a pool of contracting alternatives for MTFs to use to acquire medical services. The Military Departments formed the working group in response to the removal of many services previously provided under TRICARE. Specifically, the group's purpose is "to develop a fully integrated Tri-Service contract support system to compliment the Tri-Service health care delivery system," and its strategic goal is "to provide professional medical services to the MHS [Military Health System] through collaborative contracting methods that decrease acquisition costs and improve service delivery responsiveness." Among the group's accomplishments to date are determining the amount of services each Military Department must convert from TRICARE to non-TRICARE contracts (defining TRICARE carve-out requirements), assigning an appointing services contract award to the Army, active fostering of interagency contracting with the Department of Veterans Affairs, and creating an Air Force on-line conversion toolkit (with links to the Army's iMAP). The tri-Service group reports to the DoD/Department of Veterans Affairs Acquisition Management Committee.

**Contracting for Services.** Most recently, the OUSD(AT&L) issued a memorandum in October 2003 that requires the Military Departments and Defense Agencies to:

- report by December 31, 2003, on efforts to establish centers of excellence for services contracting, how the centers are used, and the experience gained;
- report by March 31, 2004, the acquisition practices used to ensure contracting officers appoint representatives in accordance with Defense FAR Supplement Subpart 201.602-2(5) and are properly trained in accordance with Defense FAR Supplement Subpart 201.602-2(2); and
- report by March 31, 2004, on practices in place to ensure the appropriate contract type is used when acquiring services based on the criteria specified in FAR Part 16 and Defense FAR Supplement Part 216.

We contacted the OUSD(AT&L) on May 20, 2004. No responses to the October 2003 memorandum had been received by the OUSD(AT&L).

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## **Appendix F. Report Distribution**

### **Office of the Secretary of Defense**

Under Secretary of Defense for Acquisition, Technology, and Logistics  
Director, Defense Procurement and Acquisition Policy  
Under Secretary of Defense (Comptroller)/Chief Financial Officer  
Deputy Chief Financial Officer  
Deputy Comptroller (Program/Budget)  
Under Secretary of Defense for Personnel and Readiness  
Assistant Secretary of Defense (Health Affairs)  
General Counsel

### **Department of the Army**

Assistant Secretary of the Army (Financial Management and Comptroller)  
Surgeon General, Department of the Army  
Auditor General, Department of the Army

### **Department of the Navy**

Assistant Secretary of the Navy (Manpower and Reserve Affairs)  
Naval Inspector General  
Chief, Bureau of Medicine and Surgery  
Auditor General, Department of the Navy

### **Department of the Air Force**

Assistant Secretary of the Air Force (Acquisition)  
Assistant Secretary of the Air Force (Financial Management and Comptroller)  
Surgeon General, Department of the Air Force  
Auditor General, Department of the Air Force

### **Other Defense Organizations**

Director, Defense Finance and Accounting Service  
DoD/Department of Veterans Affairs Joint Executive Council

### **Non-Defense Federal Organizations**

Office of Management and Budget  
Department of Veterans Affairs

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## **Congressional Committees and Subcommittees, Chairman and Ranking Minority Member**

Senate Committee on Appropriations  
Senate Subcommittee on Defense, Committee on Appropriations  
Senate Committee on Armed Services  
Senate Committee on Governmental Affairs  
House Committee on Appropriations  
House Subcommittee on Defense, Committee on Appropriations  
House Committee on Armed Services  
House Committee on Government Reform  
House Subcommittee on Government Efficiency and Financial Management, Committee on Government Reform  
House Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform  
House Subcommittee on Technology, Information Policy, Intergovernmental Relations, and the Census, Committee on Government Reform

# Under Secretary of Defense for Acquisition, Technology, and Logistics Comments

Final Report  
Reference



ACQUISITION,  
TECHNOLOGY  
AND LOGISTICS

## OFFICE OF THE UNDER SECRETARY OF DEFENSE

3000 DEFENSE PENTAGON  
WASHINGTON, DC 20301-3000

MAY 13 2004

DPAP/PAIC

MEMORANDUM FOR PROGRAM DIRECTOR, READINESS AND  
LOGISTICS SUPPORT DIRECTORATE, DODIG

THROUGH: DIRECTOR, ACQUISITION RESOURCES AND ANALYSIS *WJ 5/20/04*

SUBJECT: Response to DODIG Draft Report D2003LF-0127, "Non-TRICARE  
Medical Services Contracts"

As requested, I am providing the following response to the  
recommendations contained in the subject report:

**DoDIG Recommendation #2:** We recommend that USD (P&R) request that the  
Office of the Under Secretary of Defense for Acquisition, Technology, and  
Logistics (OUSD(AT&L)) establish a pilot program for acquiring non-TRICARE  
medical services.

**DPAP Response:** Concur. We believe that a coordinated acquisition strategy (as  
identified in recommendation #5a) must be developed prior to initiating a pilot  
program. The Military Departments' (MILDEPs) contracting and requiring  
program officials must work in consonance to develop the acquisition strategy  
from a joint perspective. Accordingly, we are working with the Assistant  
Secretary of Defense for Health Affairs (ASD(HA)) to identify a MILDEP  
Executive Agent who will be responsible for establishing a commodity team  
comprised of representatives from each MILDEP and other associated  
organizations, whose tasks will be to 1) develop an acquisition strategy for direct  
care medical services, and 2) recommend to OUSD (AT&L) and ASD(HA) a pilot  
program based on that acquisition strategy. We, in concert with ASD(HA), will  
monitor their performances to ensure that all aspects of strategic sourcing are  
considered in their deliberations.

Terminology  
revised



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If you have any questions regarding this memorandum, my point of contact for this issue is Mrs. Sandra Haberlin at (703)695-4259 or at [sandra.haberlin@osd.mil](mailto:sandra.haberlin@osd.mil).

*for Vincent J. Tuck*  
Deidre A. Lee  
Director, Defense Procurement  
and Acquisition Policy

# Under Secretary of Defense (Comptroller)/Chief Financial Officer Comments



COMPTROLLER

UNDER SECRETARY OF DEFENSE  
1100 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1100

MAY 14 2004

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Report on Non-TRICARE Medical Services Contracts (Project No. D2003LF-0127)

This memorandum forwards the Office of the Under Secretary of Defense (Comptroller) response to the subject draft audit report. We concur with the recommendation and our comments are attached.

The Department appreciates the opportunity to comment on the subject report. My staff point of contact on this matter is Mr. Eric R. Gibson. He may be contacted by e-mail at [eric.gibson@osd.mil](mailto:eric.gibson@osd.mil) or by telephone at (703) 693-3618.

  
Lawrence J. Lanza  
Acting

Attachment:  
As stated



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**INSPECTOR GENERAL, DEPARTMENT OF DEFENSE (OIG, DOD)  
DRAFT REPORT  
PROJECT NO. D2003LF-0127  
"NON-TRICARE MEDICAL SERVICES CONTRACTS"**

**OFFICE OF THE UNDER SECRETARY OF DEFENSE (COMPTROLLER)  
RESPONSE TO THE OIG, DOD RECOMMENDATION**

**RECOMMENDATION 4:** We recommend that if the legal review requested in Recommendation 3 determines that individual set-aside contracts are subject to Federal Insurance Contributions Act tax, that the Under Secretary of Defense (Comptroller)/Chief Financial Officer:

- a. Develop a process for future payments of Federal Insurance Contributions Act (FICA) tax for individual set-aside contracts.
- b. Direct fund holders who did not pay the required FICA tax to determine the existence of a liability and make the necessary accounting entries for Government financial statements.

**OUS(D) RESPONSE TO RECOMMENDATION 4a:** Concur. Upon receipt of a General Counsel for Health and Personnel Policy determination that individuals performing services through set-aside contracts are Department of Defense (DoD) civilian employees, this office will address the required changes for withholding FICA and other payroll taxes in our Business Modernization and Systems Integration effort.

**OUS(D) RESPONSE TO RECOMMENDATION 4b:** Concur. Upon receipt of a General Counsel for Health and Personnel Policy determination that individuals performing services through set-aside contracts are DoD civilian employees, this office will direct the appropriate fund holders to determine the existence of FICA liabilities, make the required employee withholding for FICA taxes, and make the necessary adjustments to the financial statements.

Attachment

# Assistant Secretary of Defense (Health Affairs) Comments



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

MAY 17 2004

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL  
ASSISTANT INSPECTOR GENERAL FOR AUDITING  
DIRECTOR, READINESS AND LOGISTICS SUPPORT  
DIRECTORATE

SUBJECT: Draft Report on Non-TRICARE Medical Services Contracts (Project  
Number D-2003LF-0127)

Thank you for the opportunity to review and provide comments on the subject  
draft report.

I continue to nonconcur with some elements of the report and have additional  
comments that I feel might be helpful as you draft your final report. My specific  
comments are addressed in the agency comments provided at attachment 1. In addition,  
Army and Air Force comments are at attachments 2 and 3 for your consideration.

I believe these comments will be helpful in ensuring that your final report is useful  
to the Department's medical community. Please feel free to direct any questions to my  
project officers on this effort, Ms. Suzanne Curtis (functional) at (703) 681-1143, ext.  
5420 and Mr. Gunther J. Zimmerman (General Accounting Office/Inspector General  
Liaison) at (703) 681-3492, ext. 4065.

*William Winkenwerder, Jr.*  
William Winkenwerder, Jr., MD

Attachments:  
As stated

**DEPARTMENT OF DEFENSE INSPECTOR GENERAL  
DRAFT OF A PROPOSED REPORT  
D-2003LF-0127**

**Agency Comments on Draft of a Proposed Report,  
“Non-TRICARE Medical Services Contracts”**

Agency comments are indicated below according to sections in the draft report.

**Report Title (and Throughout the Draft Report)**

**Non-TRICARE Medical Services Contracts**

Comment: Title page and throughout the report. The use of the term “non-TRICARE medical services contracts” is technically inaccurate.

1. Discussion: The proper reference would be to “Direct Care Medical Services Contracts.” TRICARE is the health care program of Department of Defense (DoD) and consists of the purchased care component (i.e., care purchased from civilian health care institutions and individual providers – including TRICARE Prime preferred provider networks and standard program non-network providers) and the direct care component (i.e., care furnished through military treatment facility (MTF) resources – including MTF military and civilian employee staff resources, as well as contracted resources augmenting the MTF staffs.) The reference in the report to non-TRICARE contracts is inaccurate because the contracts help the MTFs provide “TRICARE” services, but the distinguishing factor is that the contracts are not for the purchased care component of TRICARE but involve health care services to augment the direct care component of TRICARE.

**Background**

**Military Health System**

Comment: Page 1. The description of TRICARE (“TRICARE brings together the health care resources of the Army, the Navy, and the Air Force and supplements them with networks of civilian health care professionals to improve access to high quality services while maintaining the capability to support military operations. To help fill needs that cannot be satisfied through military treatment facilities or through TRICARE contracts, the Military Departments issue non-TRICARE contracts.”) could be more correctly stated.

Discussion: A more accurate statement of TRICARE would be:

"TRICARE brings together the direct health care resources of the Army, the Navy, and the Air Force and supplements them with purchased care contracts that provide health care through health care institutions and individual providers in the civilian community. These purchased care contracts include networks of civilian health care professionals that supplement the direct health care resources of the Military Departments to improve access to high quality services while maintaining the capability to support military operations. To help fill needs that cannot be satisfied through military treatment facilities or purchased care contracts under TRICARE, the Military Departments issue Direct Care Medical Services Contracts; that is, contracts for health care services to augment the direct health care military and employee staffs of the Military Departments."

#### Use of Contractual Resources

##### Forward Funding Contractual Work

Comment: Page 6. The Draft Report comments on the award of two contracts at Navy MTFs for work beginning on September 30 and continuing for a period one year thereafter. In accordance with 10 U.S.C 2410a (not 10 U.S.C. 2410 as indicated in the Draft Report) DoD agencies may obligate funds current at the time of the award to finance any severable service contract with a period of performance that does not exceed one year. While conceding that the practice may have been legal, the Draft Report states that because only one day of performance of the contract fell within the year of the procurement and the period of performance was well within control of the MTF that the Inspector General did not believe it met the intent of this legislation.

Discussion: The Draft Report misconstrues the intent of this legislative change. The "general rule" regarding the funding of severable service contracts is indeed that service contracts may not cross fiscal years and agencies must fund service contracts with dollars available for obligation on the date the contractor performs the services. There now exist sweeping statutory exceptions to this "general rule" for the Department of Defense, the Coast Guard and non-DoD agencies as well. The use of these exceptions, which were created in an attempt to streamline the federal acquisition process, is not premised on whether the period of performance is within the control of the agency. The reported use of this authority was legal, and was consistent with the use of this authority generally within the government as well as the letter and spirit of the underlying legislation.

Pages 15-18

### Recommendations

Pages 13-14

Recommendation 1: Recommends that the Under Secretary of Defense (Personnel & Readiness) (USD(P&R)), as co-chair of the DoD/Department of Veterans Affairs (VA) Joint Executive Council, review potential solution to barriers of DoD/VA sharing caused by statutory authority to award Personal Service Contracts.

- No comment. The TRICARE Management Activity (TMA) defers to OUSD(P&R) on this recommendation.

Recommendation 2: Recommends that the USD(P&R) request USD(Acquisition, Technology & Logistics) (AT&L) establish a pilot program for acquiring non-TRICARE medical services.

- No comment. TMA defers to OUSD(P&R) and OUSD(AT&L) on this recommendation.

Recommendation 3: Recommends that the ASD(HA) request a legal review concerning Federal Insurance Contribution Act (FICA) tax for individual set-aside contracts.

- TMA concurs.

Recommendation 4: Recommends that if the legal opinion requested above determines that individual set-aside contracts are subject to FICA tax, that OUSD(Comptroller):

- a. Develop a process for future payments of FICA tax for individual set-aside contracts.
- b. Direct fund holders who did not pay the required FICA tax to determine the existence of a liability and to make the necessary accounting entries for Government financial statements.

- TMA concurs.

Recommendation 5: Recommends that the ASD(HA), in conjunction with the Military Departments Surgeons General:

- a. Develop a coordinated strategy for acquiring non-TRICARE medical services that includes the implementation of the centers of excellence concept.
- TMA concurs.

Terminology  
revised

Terminology  
revised

- b. Develop implementing guidance for acquiring non-TRICARE medical services.  
At a minimum, issue guidance on:
  - (1) The use of personal versus non-personal contracts.
  - (2) The appropriate use of forward funding.
  - (3) The fulfillment of minimum guarantees for multiple award task order contracts.
  - (4) The use of individual set aside contracts.
- TMA concurs. While none of these four areas are exclusive to medical services contracts, OASD(HA) will fully participate in the development of any guidance impacting on the acquisition of non-TRICARE medical services.

Terminology  
revised

**Recommendation 6:** Recommends that the Military Department Surgeons General develop an oversight process for the acquisition of non-TRICARE medical services, to include at a minimum, monitoring:

Terminology  
revised

- a. Type and character of contracts used.
- b. The use of the forward funding statute.
- c. The award of minimum guarantees for multiple award task order contracts.
- d. The extent of contract competition.

- TMA concurs.

#### **Management Control Program Review**

Comment: Page 17. The Draft Report identified a material management control weakness for the Military Departments and OASD(HA). The DoD IG stated that management controls were inadequate to ensure that DoD acquired non-TRICARE medical services in the most effective manner. The Report further states that Recommendations 2, 4.a, 5, and 6, if implemented, will improve procedures that the Military Departments and OASD(HA) use for awarding and managing contracts.

Page 21

Terminology  
revised

Discussion. TMA nonconcurs with the Draft Report assessment that a material management control weakness exists within either the Military Departments or the OASD(HA). Each Military Department utilizes its own specific contracting methodology to obtain services as prescribed by the DFARS. As the DoD IG discussed, each Service has its own capability, either centralized or in the case of the Air force, accomplished at the unit level. We maintain that the Military Department strategies and practices are governed by the DFARS and Service acquisition regulations, and that adequate oversight is accomplished through their Heads of Contracting Activity (HCA). The findings discussed in this report in no way constitute the level of a material weakness. DoD is acquiring non-TRICARE medical services in the most effective

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manner when all dimensions of quality, access, local needs, and cost are taken into consideration.

To further strengthen our ability to monitor the effectiveness of acquiring non-TRICARE medical services, we will develop a new Assessable Unit (AU) for the Defense Health Program (DHP) Enterprise Management Control Program addressing this topic. This AU will be issued as a supplement to the FY 2004 Management Control Program guidance previously released to the Military Department Assistant Secretaries of Defense (Manpower and Reserve Affairs). The risk assessments conducted and potential vulnerabilities identified in response to this AU will be monitored through the DHP Enterprise Management Control Program.

# Army Surgeon General Comments

Final Report  
Reference



DEPARTMENT OF THE ARMY  
OFFICE OF THE SURGEON GENERAL  
5109 LEESBURG PIKE  
FALLS CHURCH VA 22041-3258

DASG-IRO (36-2)

4 May 2004

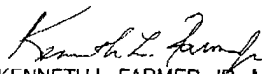
MEMORANDUM FOR Deputy Assistant Secretary of Defense (HB & FP), Suite 810,  
5111 Leesburg Pike, Falls Church, VA 22041

SUBJECT: DODIG Draft Report, Non-TRICARE Medical Service Contracts, Project No.  
D2003LI-0127, March 8, 2004

1. Reference AR 36-2, Audit Reports and Follow-up, 25 April 1991.
2. Thank you for the opportunity to review this draft report. We generally agree with the report as written and concur with report recommendation six that recommends we "...develop an oversight process for the acquisition of non-TRICARE medical services..." Our reply to recommendation six is enclosed.
3. Questions regarding this action should be directed to Mr. Tim Fannin, Internal Review and Audit Compliance, Commercial (210) 221-6164 or DSN 471-6164.

FOR THE SURGEON GENERAL:

Encl

  
KENNETH L. FARMER, JR., M.D.  
Major General  
Deputy Surgeon General

Terminology  
revised



OTSG/MEDCOM Response to DoD IG Draft Audit Report  
"Non-TRICARE Medical Services Contracts"  
Project No. D2003LF-0127, March 8, 2004

**Recommendation 6.** We recommend that the Military Department Surgeons General develop an oversight process for the acquisition of non-TRICARE medical services, to include, at a minimum, monitoring:

- a. The type and character of contracts used.
- b. The use of the forward funding statute.
- c. The award of minimum guarantees for multiple award task order contracts.
- d. The extent of contract competition.

**Action Taken. Concur.** The Army Medical Command's Procurement Management Review (PMR) program includes a management control to ensure oversight of the acquisition process. At a minimum, the Army Federal Acquisition Regulation Supplement 5101.690 requires biennial reviews of the Center for Health Care Contracting and each Regional Contracting Office to ensure they are in compliance with laws, policies, regulations and directives. The elements of recommendation 6 will be monitored during each PMR. The target date for implementation of this action is 30 September 2004.

# Air Force Surgeon General Comments



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS UNITED STATES AIR FORCE  
WASHINGTON DC

30 APR 2004

## MEMORANDUM FOR TRICARE MANAGEMENT ACTIVITY-OCFO

FROM: HQ USAF/SGO  
110 Luke Avenue, Room 400  
Bolling AFB, DC 20032-7050

SUBJECT: Air Force Inputs to DOD IG Report D2003LF-0127, Non-TRICARE Medical Service Contracts

The following information is submitted in response to the draft report of your recent audit of non-TRICARE medical services contracts:

**Recommendation 1: Concur.** Incompatible statutory authority to award personal services hinders Air Force Medical Treatment Facilities (MTFs) when contracting action is accomplished through the Department of Veterans Affairs, specifically the Veterans Administration Special Services (VASS) contracting office at Ft Detrick MD. Under 10 USC 1091, DOD may enter into personal services contracts for healthcare for its facilities, but the VA currently lacks this statutory authority. FAR 37.104 requires that agencies shall not award personal services contracts unless specifically authorized by statute. Granting the VA this authority would fully support DOD-DVA sharing arrangements and lend itself towards appropriate contracts based on the customer's requirement vice the contracting office's awarding capability.

**Recommendation 2: Concur.** Establishment of a pilot study for acquiring non-TRICARE medical services should include all the Services and the VA. The Services have accomplished several medical supply initiatives that significantly aided their MTFs in acquiring medical-surgical supplies. This same effort could be optimally applied to services acquisitions.

**Recommendation 3: Concur.**

**Recommendation 4: Concur.**

**Recommendation 5a: Concur.** Implementation of the centers of excellence concept is fully supported by AF/SG. Recent efforts begun at Wright-Patterson AFB, OH, to implement a Medical Acquisition Center of Excellence (MACOE) are highly desirable for development of a centralized contracting office available Air Force-wide to acquire, manage, and administer medical services contracts in an efficient, expeditious, standardized and cost-effective manner. The Air Force currently partners with the VASS to procure services contracts for non-personal services but, as stated previously, statutory limitations prevent use of personal services contracts. Recent changes to Air Force guidance (AFI 63-124) requires coordination of all contracting requisitions going outside the DOD through the Services Designated Official (SDO) and appropriate compliance with each AF MAJCOM's Management and Oversight of Acquisition of Services Processes (MOASP) policy. The current AF-VASS partnership could be incorporated

into an AF centralized contracting office for medical acquisitions and would thereby facilitate compliance with AFJ 63-124.

**Recommendation 5.b.(1): Concur.** Guidance on the use of personal versus non-personal services contracts would facilitate Services' acquisition of medical staffing within the MTFs. As stated previously, eliminating the incompatible statutory authority would benefit all the Services and the VA.


**Recommendation 5.b.(2): Non-Concur.** Guidance on appropriate use of funding would be beneficial, however, it should include review and perhaps revision of current funding/appropriations release policies. Current method for release of funds does not match acquisitions timelines, thus this incongruity impacts the customer's ability to submit a procurable package in a timely manner to the contracting office. As stated in the report, Title 10 USC 2410 does allow an exception; hence the practice described in the report is within the legislative guidance. We believe we are in compliance with current statutory requirements.

**Recommendation 5.b.(3): Concur.** Guidance on fulfillment of minimum guarantees for multiple award task order contracts would be appropriate.

**Recommendation 5.b.(4): Concur.** Guidance on the use of ISAs would indeed be beneficial to all the Services.

**Recommendation 6.a-d: Concur.** Development of an oversight process for acquisition of non-TRICARE medical services in the Air Force must include the Secretary of the Air Force Acquisitions (SAF/AQ), as that office maintains primary responsibility for services acquisition contracting. The Air Force Medical Service (AFMS) should identify its requirements and develop in conjunction with the Services and the VA an overall acquisition strategy for non-TRICARE medical service contracts, while SAF/AQ should facilitate the contracting processes and acquisition methodology that should be used by the AFMS. The newly formed Air Force Medical Service Commodity Council, in conjunction with the MACOE, SAF/AQ and SGSLC and the Tri-Service Medical Contracting Working Group, should collaborate in their joint development of oversight process requirements for monitoring: a) the type and character of contracts used; b) the use of forward funding statute; c) the award of minimum guarantees for multiple award task order contracts, and d) the extent of contract competition. Any of their singular efforts would not encompass the total package of strategy, methodology, and management and administration of the contracts, but a collaborative effort with all these parties would ensure that AFMS needs, as well as SAF/AQ requirements were appropriately included and addressed.

My point of contact is Lt Col Sandi Mudaris, Chief, Procurement Services Branch, AFMSA/SGSLC, DSN 343-4083, [sandra.madaris@h-detrick.af.mil](mailto:sandra.madaris@h-detrick.af.mil).

  
JOSEPH E. KELLEY  
Major General, USAF, MC, CFS  
Assistant Surgeon General, Health Care Operations  
Office of the Surgeon General

Revised

## **Team Members**

The Office of the Deputy Inspector General for Auditing of the Department of Defense, Readiness and Logistics Support prepared this report. Personnel of the Office of the Inspector General of the Department of Defense who contributed to the report are listed below.

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Michael A. Joseph  
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Lynnell E. Whitehead  
Eva M. Zahn  
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